CATERINA VIOLI, M.D. OB-GYN
2 ½ DEARFIELD DRIVE
GREENWICH,CT 06831
(203) 861-9586

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

_____
Patient Name

_____
Date of Birth

I hereby request that any communications made by Dr. Violi's office to me be made:
PLEASE CHECK ONE.

_____1. From information supplied by me in PATIENT REGISTRATION FORM, both address and phone numbers.

_____2. By alternative means (specify in space below):

_____3. At an alternative address (specify in space below):

It is acceptable to me that messages be left on my answering machine.

I would like all future communications to me to be made in accordance with my wishes as expressed above. I understand that if I refuse to specify an alternate address or to provide information as to how payment, if any, will be handled, Dr. Violi's office may deny my request.

_____
Signature of Patient of Personal Representative

_____
Relationship to Patient

_____
Date